

No. 2
-9-43
-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4528**
Registrar's No. **162**

FILED MAR 1 1948

Registration District No. **138**

Primary Registration District No. **2000**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **GREEN**

(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St Johns Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **6 hrs**
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **Hickory #3**

(c) City or town **Cross Timbers**
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Bookie Joe Little**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **NO**

4. Sex **Male** 0

5. Color or race **w**

6. (a) Single, widowed, married, divorced **Single** 0

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **2 - 18 - 1948**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
1	1	1	7 hr. _____ min.

9. Birthplace **Springfield MO**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name **W. C. Little**

13. Birthplace **Fairfield MO**
(City, town, or county) (State or foreign country)

14. Maiden name **Josephine Davis**

15. Birthplace **Kristol MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **W. C. Little**

(b) Address **Cross Timbers, MO**

17. (a) **Burial** (b) Date thereof **Feb 19-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cross Timbers Cemetery**

18. (a) Signature of funeral director **Silbert Hathaway**

(b) Address **Whetland, MO**

19. (a) **2/19/48** (b) **W. S. Handley MD**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **18**
year **1948** hour **10** minute **10 A.** M.

21. I hereby certify that I attended the deceased from **2-18-48** to **2-18-48**, 19 **48**
that I last saw him alive on **2-18-48**, 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death **Term pregnancy 31 wks - Prematurity**
Due to **Premature labor and preeclampsia**
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **J. L. Johnston** (M. D. or other) **MD**
Address **Springfield, MO** Date signed **2/18/48**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.